EPI-LOG

Communicable Disease and Epidemiology News
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Influenza Surveillance, Vaccine Recommendations, Treatment and Prophylaxis, Vaccine Supply and Frequently Asked Questions

Surveillance

The leaves are changing color, sentinel influenza providers have begun swabbing throats, and long term care facilities are on high alert for clusters of influenza-like-illness (ILI); October is here; time to officially kick-off seasonal influenza surveillance.

Since the first week in October, King County sentinel providers have submitted 20 specimens from patients with ILI; none have been positive for influenza. Regular updates on local influenza activity and surveillance are available at: www.metrokc.gov/health/immunization/fluactivity.htm

National influenza surveillance, for the week ending October 21st, shows Louisiana and Hawaii reporting local influenza activity, and Alabama, California, Connecticut, Florida, Iowa, Massachusetts, Mississippi, New York, and Texas reporting sporadic activity. National influenza updates can be found at: www.cdc.gov/flu/weekly/fluactivity.htm

Vaccine Recommendations

Trivalent influenza vaccine is available as an injectable inactivated vaccine (TIV) and a live attenuated intranasal vaccine (LAIV).

For the 2006-2007 season, vaccination with TIV is recommended for:

- Children aged 6 to 59 months;
- Children and adolescents (aged 6 months to18 years) who are receiving long-term aspirin therapy;
- Women who will be pregnant during the influenza season;
- Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma (hypertension is not considered a high-risk condition);
- Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunodeficiency (including immunodeficiency caused by medications or by human immunodeficiency virus);
- Adults and children who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration;
- Residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions; and
- Persons aged >50 years.

Vaccination with TIV *or* LAIV is recommended for the following persons, unless contraindicated:

- Healthy household contacts and out-of-home caregivers of children aged 0 to 59 months and others at high risk for severe complications from influenza (Note: LAIV is only licensed for persons age 5 through 49 years); and
- Health-care workers

Treatment and Prophylaxis

CDC and ACIP recommend that neither amantadine nor rimantadine be used for the treatment or chemoprophylaxis of influenza A in the United States at this time because of decreased susceptibility to these antiviral medications among circulating influenza A viruses. Oseltamivir or zanamivir can be prescribed if antiviral treatment of influenza is indicated. Oseltamivir is approved for treatment of persons aged 1 year and older, and zanamivir is approved for treatment of persons aged 7 years and older. For chemoprophylaxis of influenza, oseltamivir is licensed for use in persons 1 year and older, and zanamivir is licensed for use in persons 5 years and older.

Vaccine Supply

Health care providers nationwide are experiencing delays in receiving flu vaccine, with orders not reaching many until November. According to manufacturers, all doses are expected to arrive before the usual peak of the flu season, typically late December to March. The projected influenza vaccine supply for the US is projected to be about 100 million doses (an increase of 16% over last year), so the CDC is not recommending a tiered vaccination strategy.

On another front, 500,000 doses of FLUVIRIN (Novartis, formerly Chiron) intended for the Vaccines for Children programs nationwide reportedly froze during shipment, and were recalled by the manufacturer. None of the affected doses were distributed in King County.

Frequently Asked Questions

Q: Who can receive FluMist, the live-attenuated influenza vaccine (LAIV)?

A: FluMist, the intranasally administered flu vaccine, is an excellent option for vaccination of healthy, non-pregnant persons aged 5-49 years, including health care workers. Possible advantages of LAIV include its potential to induce a broad mucosal and systemic immune response, its ease of administration, and the acceptability of an intranasal rather than intramuscular route of administration.

Q: Can persons receive LAIV (FluMist) if they care for, or have contact with someone who is immune compromised?

A: A person should not receive LAIV if he or she is in contact with someone with a severely weakened immune system *being cared for in a protective environment* (for example, a hematopoietic stem cell transplant patient). However, LAIV may be given to those who have contact with people with lesser degrees of immunosuppression (for example, diabetic patients, persons with asthma on corticosteroid therapy, or HIV infected persons).

Q: If a child between 6 months and 9 years of age received their first dose of influenza vaccine last year, but didn't receive a booster dose of vaccine last year, how many doses of influenza vaccine do they need this year?

A. They should receive one dose of influenza vaccine this year. **Whenever possible, children between 6 months and 9 years, who are vaccinated for influenza, should receive both the initial dose and the booster dose prior to the beginning of the flu season.** If the initial dose is TIV, a booster dose of TIV *or* LAIV (for children ≥ 5 years old) should be given at least 4 weeks later. If the initial dose is LAIV, a booster dose of LAIV *or* TIV should be given at least 6 weeks later.

Q: How late in the season should I continue to offer influenza vaccine?

A. When possible, October and November are the optimal months for people to receive influenza vaccine, but vaccination efforts should routinely continue throughout flu season as long as vaccine supplies are available. In Washington State, flu season generally peaks in February, and cases continue to occur through the spring. Offer your patients flu vaccine even after influenza activity has begun in the community.

Pandemic Planning Alert: The US Department of Health and Human Services (HHS) recently posted revised "Interim Guidance on Planning for the Use of Surgical Masks and Respirators in Health Care Settings during an Influenza Pandemic".
Review the document at:
www.pandemicflu.gov/plan/maskguidancehc.html

West Nile Virus Found in King County Birds

Since the beginning of October, West Nile virus has been detected in four crows and one hawk found in King County. The crows each were found in the Seattle neighborhoods of Magnolia, Broadview/Blue Ridge, and Laurelhurst, and the East Hill neighborhood of Kent. The infected hawk was found in the Somerset neighborhood of Bellevue. These birds are the first confirmation that West Nile virus is present in King County. As yet, no locally acquired human cases of West Nile virus infection have occurred in King County residents. A Pierce County husband and wife, and a Clark County man are the only Washington State residents diagnosed with West Nile virus infection who did not travel outside Washington State during their respective exposure periods. For West Nile virus laboratory testing and case reporting guidelines, see: www.metrokc.gov/health/providers/epidemiology/health-alert-050531.htm

Disease Reporting

AIDS/HIV ..... (206) 296-4645
STDs ..... (206) 731-3954
TB ..... (206) 731-4579
All Other Notifiable Communicable Diseases (24 hours a day) .... (206) 296-4774
Automated reporting line for conditions not immediately notifiable ..... (206) 296-4782

Hotlines

Communicable Disease ..... (206) 296-4949
HIV/STD ..... (206) 205-STDS

Reported Cases of Selected Diseases, Seattle & King County 2006

	Cases Reported in September		Cases Reported Through September	
	2006	2005	2006	2005
Campylobacteriosis	32	41	204	259
Cryptosporidiosis	6	4	29	59
Chlamydial infections	468	382	3,902	4,190
Enterohemorrhagic *E. coli* (non-O157)	0	1	2	6
***E. coli* O157: H7**	1	12	33	27
Giardiasis	15	16	87	108
Gonorrhea	147	140	1,489	1,311
***Haemophilus influenzae* (cases <6 years of age)**	0	0	2	2
Hepatitis A	1	1	11	13
Hepatitis B (acute)	0	0	10	17
Hepatitis B (chronic)	90	75	634	576
Hepatitis C (acute)	0	0	6	6
Hepatitis C (chronic, confirmed/probable)	110	109	1,108	998
Hepatitis C (chronic, possible)	21	32	227	289
Herpes, genital (primary)	80	36	622	579
HIV and AIDS (including simultaneous diagnoses with AIDS)	34	N/A*	194	271
Measles	0	0	0	1
Meningococcal Disease	0	0	7	13
Mumps	0	0	2	1
Pertussis	8	38	91	230
Rubella	0	0	0	1
Rubella, congenital	0	0	0	0
Salmonellosis	15	24	146	173
Shigellosis	7	9	40	54
Syphilis	9	13	164	121
Syphilis, congenital	0	0	0	0
Syphilis, late	10	4	65	57
Tuberculosis	14	9	113	85

*Comparison of HIV/AIDS reports with other states resulted in reclassification of several Washington State cases as having an initial diagnosis in another state; consequently, they were removed from the analysis presented in this table.

The *EPI-LOG* is available in alternate formats upon request.